TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marcus P. Hayes, D.C.

Respondent Name
Sentinel Insurance Company

MFDR Tracking Number
M4-15-3569-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the DD addressed MMI (with subsequent IR determination), extent of injury, return to work status and disability as a direct result. Therefore, all were addressed as the treating doctor was in disagreement with the DD's findings … Therefore, the billing codes submitted reflected the issues addressed by the DD as per sections 408.0041 (f-2) and 408.0041 (h) of the Texas Labor Code & Rule §126.17.

Therefore, AI&FATC requests The Hartford to remit the balance due of $375.00 for the alternate DD return to work status and disability as a direct result performed…"

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Modifier 'RE' represents return to work (RTW and/or evaluation of medical care (EMC). Reimbursement for this service is $500."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2015	Referral Doctor providing alternate opinion to DD: Return to Work/Disability direct result of Compensable Injury (99456-RE)	$375.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursement of Division-

specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 296 – Service exceeds maximum reimbursement guidelines.
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 10 – The billed service requires the use of a modifier code.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code "4 – The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Administrative Code §134.204 (k) states, in relevant part,

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting **a Division or insurance carrier requested** [emphasis added] RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports…

Review of the submitted documentation indicates that the disputed services involve CPT Code 99456-RE for an examination to determine the ability of the injured employee to return to work and an examination to determine if disability was a direct result of the compensable injury. The Report of Medical Evaluation (DWC069) indicates that this examination was performed by a doctor referred by the treating doctor. Documentation does not support that the examination was requested by the Division or the insurance carrier. For this reason, the billed procedure code and modifier were not supported. Therefore, the insurance carrier's denial reason is substantiated. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	July 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.